DEPARTMENT OF THE NAVY
NAVAL HEALTHCARE SUPPORT OFFICE
BOX 140
JACKSONVILLE FL 32212-0140

INPUT THE FOLLOWING DATA PRESS TAB TO START

RANK NAME

SSN DESIGNATOR

CORPS(DC,DT,MC,MSC,NC,WO)

This information will be used to fill fields on this form. Print out this form, follow the directions and send the package to us. Certified mail is the preferred way to return the package.

Print Package

CREDENTIALS CHECKLIST

You MUST provide copies of all items marked with an "X", obtained within the last two years, before processing of your renewal package can begin.

X All Post-Graduate Training within the past two years (e.g. Residencies, Fellowships, Masters Degree, etc.)

X All Current State Licenses/Certifications.
Include DEA and/or CDS as applicable.

X Any Expired or Inactive State License/Certificate.
Include Statement of Circumstance for state license/certificate placed in an INACTIVE status or allowed to EXPIRE within the past 10 years, if not previously submitted.

X All Boards or Professional Certifications.

X Photograph (Recent. Need NOT BE official. May not be a xerox copy.) MUST be labeled with name and SSN and date.

Please provide copies of all checked items indicated in enclosure (1) and complete the forms in their entirety as identified in the cover letter and enclosure (2).
USE ONLY BLACK INK
TO CORRECT AN ERROR, DRAW A SINGLE LINE THROUGH THE ERROR, IN BLACK INK, AND INITIAL TO THE RIGHT OF THE LINE.
DO NOT USE CORRECTION FLUID/TAPE UNDER ANY CIRCUMSTANCE

These guidelines should assist you with the completion of the renewal package:

PERSONAL AND PROFESSIONAL INFORMATION SHEET (PPIS):
1. DEMOGRAPHICS:
Complete all information requested. Complete day/month/year time frames in the "from-to" fields. If the information is not applicable, write "N/A" in the space and draw a line through the remaining lines. Sign and date in the appropriate space. Please address the information regarding professional liability carrier and participation in continuing education. Should you wish to attach a curriculum vitae/resume, ensure it is current. Please initial and date on each page in the lower right corner.

2. PROFESSIONAL EDUCATION AND TRAINING:
Identify any new training completed within the past 2 years and submit copies of the diplomas.

3. HEALTH STATUS/ABILITY TO PERFORM:
Please respond to the questions that address this area. If you answer "yes" (except 2a) to any of the questions, provide a brief, factual response in the spaces below the questions.
Do not send a copy of a physical examination.

4. MALPRACTICE, LICENSURE, PRIVILEGING ACTION, AND LEGAL HISTORY (YES OR NO):
Please respond to the questions that address this area. If you answer "yes" to any of the questions, provide a brief, factual response in the spaces below the questions. In addition you will need to provide the malpractice carrier name, address and phone number, policy number, dates of coverage and coverage amount.

5. PROFESSIONAL LIABILITY: Self-explanatory.

6. OTHER INFORMATION: Self-explanatory.

7. RESERVE INFORMATION: Please complete the information regarding Naval Reserve Unit, Naval Air Reserve or Naval & Marine Corps Reserve Center, Naval Reserve Readiness Command as applicable.

8. RESERVE TRAINING: Self-explanatory.

9. CONTINUING EDUCATION HOURS: Self-explanatory.

10. PEER REFERENCES: Ensure all addresses and phone numbers are complete and accurate.

PEER - is a person who has equivalent education and training, and has worked with you in same specialty.

PEER - is not a family member or partner.

Please complete the civilian employment/civilian facilities section where privileges were held during the past two years. Provide the names, complete address and phone numbers of two peers who can attest to current competence for each specialty for which you are requesting core privileges. CCPD will mail the two peers identified on your PPIS, form NHSOJAX 6010/3 Peer Inquiry for completion. In addition, a copy of your signed and dated consent and release form, a copy of the core privilege sheet(s) and a self-addressed envelope addressed to the Naval Healthcare Support Office will be included (so that the individuals can mail them directly upon completion).
The Centralized Credentials Review and Privileging Department (CCPD) will also send form NHSOJAX 6010/6 Civilian Employment Credential/Privileging Inquiry to the Chief of Service/Department Head and/or Human Resource Office/Credentialing Department of all places of employment held since the granting of your last set of privileges.

11. PROFESSIONAL ASSIGNMENTS: Self-explanatory.

CORE PRIVILEGE SHEETS - INDEPENDENT PRACTITIONERS ONLY:
You should request core privileges to the maximum Naval Officer Billet Code(s) (NOBC) and Subspecialty Code(s) you hold and are assigned by the Bureau of Medicine and Surgery and where you can demonstrate current competence. Please include your BUMED assignment letter with your application.

Naval Healthcare Support Office may only approve and grant core privileges; should you desire supplemental or itemized privileges, you must request them from the gaining activity/mobilization site---Medical or Dental Treatment Facility.

DRUG ENFORCEMENT AGENCY CERTIFICATES (DEA)/CONTROLLED DANGEROUS SUBSTANCE CERTIFICATES (CDS): Please submit a current copy of your DEA and/or CDS certificate (as applicable).

NATIONAL PRACTITIONER DATA BANK (NPDB) QUERIES:
CCPD must query the NPDB for independent practitioners requesting core privileges at the time of initial privileging and every two years thereafter.

CONSENT and RELEASE/PRIVACY ACT and DISCLOSURE STATEMENT:
Please read, sign and date in the appropriate space.

APPLICATION FOR CORE PRIVILEGES - INDEPENDENT PRACTITIONERS ONLY:
The application is for Medical Corps officers, Dental Corps officers, Medical Service Corps/Chief Warrant officers (not Healthcare Administrators), and Nurse Corps officers (only for Advance Nurse Practitioners as recognized by the Bureau of Medicine and Surgery). Please sign and date the application for core privileges after completing section (1) and (3) on the form.

Question 1 -- initial only one request as it relates to the core privileges that you are requesting for either an Active Staff or Modification of Staff Appointment.

(a) Active Staff core privileges are granted for a two year period in accordance with BUMED Medical Staff Bylaws.

(b) Modifications are done when you desire to add core privileges to those Active Staff core privileges you have already been granted within the current privileging period and where you can demonstrate current competence.

Question 3 -- please read and initial all blanks (a - g).

PHOTO:
Please provide a recent photograph, preferably a professional photograph of yourself alone & without other family members, friends or pets. It may be a Polaroid, but not a xerox copy. Ensure that the photograph is labeled with your name, social security number and date.

OTHER PROFESSIONAL DOCUMENTS:
You may submit copies of any other associated training (CME/CEU) to your profession completed within the past 2 years. This is not required, however, you will attest to CME/CEU participation on the PPIS and application for core privileges.

NHSOJAXINST 6010.1F
NAVAL HEALTHCARE SUPPORT OFFICE
CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT
BOX 140 CODE 07
JACKSONVILLE, FLORIDA 32212-0140

PERSONAL AND PROFESSIONAL INFORMATION SHEET - PRIVILEGED PROVIDER

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.
PURPOSE: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and recommendations as to the practitioners' competence to treat certain conditions and perform certain medical procedures and to determine clinical support staff providers' competence.
ROUTINE USE: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in limitation or termination of clinical privileges.

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "YES" answers require full explanation in the comments section or an attached sheet of paper (indicate by number and section on the attached paper those items being commented upon.)

1. Rank, Name, SSN, Designator, Corps:

Maiden/Alias (Last, First, MI): _____

Core Privileges requested: _____

NOBC/SSP codes: _____ Date of Birth: _____

Are you Board eligible (Y/N): _____ Are you Board certified (Y/N): _____

Home Address: _____

Home Phone: (____) _____ Fax: (____) _____

Work address: _____

Work Phone: (____) _____ Email: _____
Note: (Please indicate which is the best method to be contacted.) _____

2. PROFESSIONAL EDUCATION AND TRAINING: (if you have attended any training, list most recent training in the past two years.) Residency (RES), Fellowship (FEL), additional Degrees

Institution (Name and Location)	SpecialtyType	From	To
_____	_____	_____	_____
_____	_____	_____	_____

I hereby attest that I understand the requirement that I be certified in a CPR course provided by the American Heart Association/HEALTHCARE PROVIDER or the American Red Cross/PROFESSIONAL RESCUER while I am in the Naval Reserves per BUMEDINST 1500.15A. I understand that I am responsible for providing documentation of my certificate upon request (i.e. AT, ADT, IDTT).

Signature: _____ Date: _____

RE:

3. HEALTH STATUS AND ABILITY TO PERFORM: (ANSWER Yes or No)
(Note: Explain all Yes answers in comments Section.)

__a. Have you met the Navy's requirement to have a completed annual physical examination, either long or short form, within the past 12 months? (If not, please explain.)
__b. Do you currently have any physical or mental impairments that could limit your clinical performance?
__c. Are you currently taking any medications?
__d. Do you have a potentially-communicable disease?
__e. Have you ever been hospitalized for any reason during the last 5 years?
__f. Have you ever been psychiatrically hospitalized or diagnosed with a major psychiatric disorder?
__g. Are you currently under or have you ever received treatment for an alcohol or drug related condition?
__h. Have you ever been arrested or detained for an alcohol or drug-related incident?
__i. Have you ever been involved in the unlawful use of controlled substances?

Comments: _____

_____

4. MALPRACTICE, LICENSURE, AND LEGAL HISTORY: (Yes or No)
(Note: Explain ALL YES answers in Comments Sections.)

__a. Have you ever been denied a staff appointment or had your privileges suspended, limited, revoked, or had a renewal/appointment denied?
__b. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)
__c. Have you ever been the subject of investigation resulting in the termination of employment or a contractual arrangement?
__d. Have you ever been charged or a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)
__e. Have you ever voluntarily resigned or otherwise disassociated yourself from employment or practice after being notified of intent to start action against you for failure to properly accomplish your professional responsibilities?
__f. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated your staff appointment (membership)?
__g. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated, or lost your clinical privileges?
__h. Have there been previously successful or currently pending challenges, revocation, or restriction to any license, certification, or registration (State, district, or Drug Enforcement Agency) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?
__i. Are you now or have you ever been required to appear before any medical or state regulatory authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?

Comments: _____

_____

5. PROFESSIONAL LIABILITY

a. Are you employed by a healthcare facility or agency and covered under their professional liability insurance?
YES___ NO___ (If no please answer questions (1) through (5) below.)

(1) CARRIER NAME/PHONE NUMBER: _____

(2) CARRIER ADDRESS: _____

(3) POLICY NUMBER: _____

RE:

(4) AMOUNT OF COVERAGE: _____

(5) DATES OF COVERAGE: _____

6. OTHER INFORMATION (Include any additional information that you wish to bring to the attention of the privileging authority.)

_____

_____

_____

_____

7. RESERVE INFORMATION

a. RESERVE UNIT and RUIC: _____

b. READINESS or RESERVE CENTER and UIC: _____

c. NAVAL AIR RESERVE OR RESERVE CENTER: _____

d. READINESS COMMAND (REDCOM): _____

e. BILLET ASSIGNED: _____

8. RESERVE TRAINING

a. OIS/DCO (Officer Indoctrination School/Direct Commissioned Officer School) Completion Date: _____

b. List ANNUAL TRAINING (AT), ACTIVE DUTY FOR TRAINING (ADT), and ACTIVE DUTY FOR SPECIAL WORK (ADSW) during the past two years.

Facility/Location	Clinical	From	To
(Example) NH Groton	YES/NO	12SEP94	29SEP94

c. Do you perform clinical drills at a military treatment facility? _____
If yes, provide information listed below for the:

Facility/Location	Capacity	Frequency
(Example) NH Jacksonville	Orthopedic Surgeon	48 drills/year

RE:

9. CONTINUING EDUCATION HOURS

Have you fulfilled the state licensure requirements for continuing education during the past 2 years?
YES ____ NO ____ (If not, please explain.)

Have you participated in continuing education in each requested area of specialization during the past 2 years? (i.e., Flight Surgery, Internal Medicine)
YES ____ NO ____ (If not, please explain.)

Comments: _____

_____

10. DEPARTMENT DIRECTOR/CHIEF OF SERVICE REFERENCE:

Name _____ Work Phone (____) _____ FAX (____) _____

Full Address _____

11. PEER REFERENCES Please provide two peer references (same specialty, i.e. Clinical Dietician/Clinical Dietician, Internal Med/Internal Med, General Dentist/General Dentist, Family Nurse Practitioner/Family Nurse Practitioner) who can attest to your qualifications based on current clinical experience within the past two years. NOTE: Two peers are required for each set of core privileges requested (attach additional sheets as necessary).

Name _____ Work Phone (____) _____ FAX (____) _____

Full Address _____

Name _____ Work Phone (____) _____ FAX (____) _____

Full Address _____

12. PROFESSIONAL ASSIGNMENTS Please provide all information requested for each place (Civilian/ Military/ Private Practice) you have been employed/held privileges since completing your respective training program (i.e. Medical School, PA Program, FNP Program, etc). Indicate if direct patient care was involved. If yes, was it in your current specialty? List in chronological order with the most recent first, and identify gaps in employment history (attach additional sheets as necessary).

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

Direct Patient Care (Y/N) ____ if yes, how many hours per week? _____

Privileges held (Y/N) __ Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

RE:

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Privileges held (Y/N) __ Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Privileges held (Y/N) __ Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

** If currently working in a non-clinical setting, or working less than 10 clinical hours a week, briefly describe your current occupation and job activities**:

_____

_____

_____

I affirm and attest that the information I have provided is complete and correct. I have the responsibility to comply with Medical/Dental Staff policies and procedures, and BUMED Bylaws and Code of Ethics/Standards of Conduct. I will keep my file current by informing the Naval Healthcare Support Office, Jacksonville, Florida of any changes, including but not limited to: my demographic information, my state license(s)/certification(s), any change in my medical staff/employment status at any facility, any change in my professional liability insurance coverage, or the filing of a lawsuit against me.

Signature: _____ Date: _____

NHSOJAXINST 6010.1F

INDIVIDUAL CREDENTIALS/PROFESSIONAL FILE
CONSENT AND RELEASE/PRIVACY ACT STATEMENT

RE:

As a clinical support staff member or by applying for medical/dental staff membership of the Naval Healthcare Support Office, Jacksonville, Florida, I hereby make the following authorizations:

REFERENCES: Authorize the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives to consult with my current and prior associates and others who may have information regarding my clinical competence and other qualifications and to verify information in my file;
INSPECTION OF RECORDS: Consent to the inspection by the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, of all records and documents, that would evaluate my competence and professional, moral, and ethical qualifications;
LIABILITY INSURANCE: Authorize release of information from current and prior liability insurance carrier(s) regarding any and all information related to coverage and claim history under their company(ies);
RELEASE FROM LIABILITY: Release from liability any and all individuals and organizations who provide information to the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, in good faith and without malice concerning my clinical competence, ethics, moral character and any other qualifications. (Peer review activities are protected under the Health Care Quality Improvement Act of 1986 (HCQIA).).
TIME FRAME FOR AUTHORIZATION: Acknowledge that this form and any copies thereof may be used as authorization for securing information for two years from the date signed.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN): 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397. 2. PURPOSE: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials and privileging function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.
3. ROUTINE USE: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
4. DISCLOSURE IS MANDATORY: In the case of all personnel, the requested information is mandatory because of the need to document all credentialing and quality assurance (performance improvement) data. If the requested information is not furnished, further action on your ICF/IPF will not be possible. This all inclusive privacy act statement will apply to all requests for personal information made by personnel for credentials review purposes and will become a permanent part of your ICF/IPF.

Your signature acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF MEMBER	SSN OF MEMBER	DATE

DATE: _____

From:

To: Officer in Charge, Naval Healthcare Support Office, Jacksonville, FL 32212-0140

Subj: STAFF APPOINTMENT WITH CLINICAL CORE PRIVILEGES

Ref: (a) BUMEDINST 6320.66C

Encl: (1) BUMED Assignment of Medical Department Classification (NOBC)/Subspecialty (SSP)/Additional Qualification Designator (AQD) Codes ltr of _____

(2) Clinical Core Privilege Sheet(s)

1. I request a Staff Appointment for the attached core privileges based on Subspecialty Codes assigned by the Bureau of Medicine and Surgery in enclosure (1).

(Please initial by request)

a. __A Renewal of Staff appointment with clinical core privileges as reflected in enclosure (2).

2. __My Individual Credentials File provides information to support this application.

3. I certify that (Please initial each applicable area):

a. I possess the credentials and current clinical competence to request the clinical core privileges for staff appointment.

b. __I have the ability to perform clinical core privileges requested.

c. __I have access to and agree to comply with the applicable credentials review and privileging directives.

d. __I have been provided a copy of have, access to, or have read, and agree to comply with Medical/Dental Staff policies and procedures, and BUMED Bylaws and Code of Ethics/Standards of Conduct.

e. __To my knowledge, I am not currently under any investigation involving substandard clinical practice, malpractice, or personal misconduct.

f. __I pledge to provide for the continuous care of my patients as predicated on professional ethics.

g. __I participate in continuing education in accordance with regulatory guidelines.

h. __I have no current mental or physical impairment that could limit my clinical abilities.

i. __I will notify the privileging authority and my commanding officer (if different from the privileging authority) of any change in my mental or physical condition that could limit my clinical ability or performance.

Subj: STAFF APPOINTMENT WITH CLINICAL CORE PRIVILEGES

Provider Signature Date

FOR ECOM/DS USE ONLY:

Recommended _____ Not Recommended _____
"Confirmed the SNO's ability to perform statement"

Comments: _____

Date: _____ Signature ECOM/DS Member: _____